



COMPANY: \_\_\_\_\_  
**HEALTH REIMBURSEMENT ARRANGEMENT  
 REIMBURSEMENT REQUEST FORM**

Name	SS#	
Home Address	Address Change: <input type="checkbox"/> Yes <input type="checkbox"/> No	
City	State	Zip
Phone: Work (    )                      Home/Cell (    )	Email:	

Complete the information below for expenses incurred by you, your spouse, or dependent children for which you request reimbursement. You must provide receipts or other evidence the expenses were incurred. Be sure to provide all information requested on this form. If the form is incomplete it will be returned to you. Print or type the information requested, then sign and date the form. Mail or fax this form and supporting documentation to your Employer.

<b>HRA MEDICAL EXPENSES</b>					
	Provider of Service (Doctor, etc.)	Person Receiving Service	Dates of Service (MO/DAY/YR)	Amount of Expense Claimed	Nature of Expense
1				\$	
2				\$	
3				\$	
4				\$	
5				\$	
6				\$	
7				\$	

I request payment from my health reimbursement account as indicated above for the expenses listed. To the best of my knowledge and belief, my statements in this reimbursement request are complete and true. I am claiming reimbursement only for eligible expenses incurred during the plan year and for my eligible dependents. I certify that these expenses have not previously been reimbursed under this or any other benefit plan and will not be claimed as an income tax deduction. I authorize my Health Reimbursement Arrangement account to reimburse me by the amount requested.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**FILING INSTRUCTIONS**

Submit claim and expense documentation to:

The Seneca Group  
 68 South Service Rd., Ste. 100  
 Melville, NY 11747  
 Fax: 866-207-5262  
 Email: Service@thesenecagroup.com